TITLE 9. HEALTH SERVICESEXHIBIT B. MIDWIFE LICENSE APPLICATION FORM
DIVISION OF FAMILY HEALTH SERVICES
APPLICATION PART I
MIDWIFE APPRENTICESHIP DOCUMENTATION
GENERAL INFORMATION

Name:_____Date:_____

Date of Birth:_____ Social Security Number_____

DatesAddress:_____

_____ 2 X 2 PHOTOGRAPH

Phone (home):_____

Phone (work):_____

Accepted for exam on: ENCLOSE FILING FEE OF $25.00
TESTING FEE IS $100.00

Core Subjects:	Grade:	Study Completed at:
Anatomy & Physiology	_____	_____
Embryology/Genetics	_____	_____
Pharmacology	_____	_____
Psychology	_____	_____
Nutrition	_____	_____

II. Practical Experience Grade:
Prenatal visits (60) _____
Observe birth (10) _____
L & D Management (25) _____
Newborn Exams (25) _____
Postpartum Exam (25) _____
Childbirth Prep class (6) _____
Physical Assessment Adult & NB _____

General Experience Grade:
Overall Care _____
Recognition & Intervention
of norm., abnormal & emerg._____
Universal Precautions _____
Technique of obtaining spec. _____
Techniques of record manage. _____

(Refer to attached detail)

III. American Heart Association CPR Certification Exp. Date
CPR Adult & Infant (Certified copy of cards enclosed) _____

IV. Letters of Recommendation
Three letters of recommendation must be mailed directly to the Program Manager from the following individuals: your preceptor, a physician or certified nurse midwife, and a client.
Have you ever been convicted of a felony? Yes No
Have you ever been convicted of a misdemeanor? Yes No
Explanation:_____

_____

By signing this application, I certify under penalty of law that the information provided anywhere in this application is true, correct, and complete to the best of my knowledge and belief. I also acknowledge that, should investigation at any time disclose any misrepresentation or falsification, my license will be revoked, denied, or suspended. I also authorize the Department to make all necessary and appropriate investigations allowable by law to verify the information provided:

_____
Applicant Date

Social Security # _____ E-mail address _____

DIVISION OF FAMILY HEALTH SERVICES
APPLICATION PART II
VALIDATION OF MIDWIFERY APPRENTICESHIP

Date:_____

Name:_____

Address:_____

Apprentice time period. Began on:_____ Completed on:_____

Preceptor Name & Title:_____

Address:_____ Home Phone:_____

Work Address:_____ Work Phone:_____

(Enclose a copy of your current license and circle the expiration date.)

By signing this application, I certify under penalty of law that the information provided anywhere in this application is true, correct, and complete to the best of my knowledge and belief. I also acknowledge that, should investigation at any time disclose any misrepresentation or falsification, my license will be revoked, denied, or suspended. I also authorize the Department to make all necessary and appropriate investigations allowable by law to verify the information provided:

_____

Preceptor's Signature Date

_____

Notary / Expiration Date Date

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1).

EXHIBIT C. PRECEPTOR RATING GUIDE
The following assessment form is provided to act as a guide for the preceptor and student. This guide will act as a standard to measure student strengths and opportunities for improvement.
1. Excellent: Demonstrates consistently high level of performance using sound scientific principles for practice, able to motivate patient and family in practice, uses consultation, requires minimal supervision.

2. Above Average: Generally performs with competence but requires periodic supervision, uses consultation appropriately, applies sound scientific principles to practice, protects patient's safety and dignity.

3. Average: Performs procedures adequately but needs supervision, can answer questions relative to underlying scientific principles, practice more self-centered than client-centered.

4. Below Average: Needs considerable supervision, can perform skills if has them demonstrated or reinforced; knows most of the principles underlying procedures but needs help in making application in the situation.

5. Unacceptable: Cannot perform skill with even minimal competence, does not know or understand principles underlying the procedures to be performed, practices inappropriately so as to threaten patient's safety, dignity, or comfort. Unable to judge.

EXHIBIT D. RENEWAL APPLICATION FORM
ARIZONA DEPARTMENT OF HEALTH SERVICES
FAMILY HEALTH SERVICES
WOMEN'S AND CHILDREN'S HEALTH
APPLICATION FOR BIENNIAL RENEWAL OF MIDWIFE LICENSE

1. NAME:_____ 2. MIDWIFE LICENSE NUMBER:_____
Last First Middle

3. SOCIAL SECURITY NUMBER:_____ 4. DATE OF BIRTH:_____
(day/month/year)

5. HOME ADDRESS: _____ (_____)_____
Street Address Area Code/Telephone Number

_____
Mailing Address (if different from street address)

_____E-Mail address _____
City County State Zip

6. BUSINESS ADDRESS:

_____
Business Title

_____ (_____)_____
Street Address Area Code/Telephone Number

_____
Mailing Address (if different from street address)

_____
City County State Zip

7. CONSUMER LISTING:
A listing of the licensed midwives is maintained for ADHS use. Consumers and various groups request copies of the listing of licensed midwives. Do you wish to have your name on this list? Yes _____ No _____
If yes, which name, address, and phone number would you like to have on that list?

_____
Name and Business Title

_____ (_____)_____
Street or Post Office Box Area Code/Telephone Number

_____
City County State Zip

8. ATTENDING DELIVERIES:

1) If you do not plan to attend any births during the next licensure period (July 1 to June 30), please complete the following statement. I do not plan to attend any deliveries as a licensed midwife from July 1, ____ to June 30, ____.
Signature:_____

2) If you do attend births after signing this statement, you must submit quarterly reports.

9. MIDWIFERY PRACTICE:

1) Have you had any maternal deaths during the past licensure period? Yes ____ No ____.
If yes, give client name and number.

_____

2) Have you delivered any stillborn infants during the past licensure period?
Yes ____ No ____. If yes, give client name and number.

_____

3) Have any of the infants you delivered died within the first 28 days of life?
Yes____ No ____. If yes, give client name and number.

_____

10. Do you have any communicable diseases (i.e., tuberculosis, rubella, hepatitis, etc.)?
Yes ____ No ____. If yes, please explain on a separate sheet of paper.

11. Besides your midwifery license, do you hold any other licenses in Arizona as a health care provider (i.e., R.N., E.M.T.,N.D., etc.)?
Yes ____ No ____. If yes, what other licenses do you hold?_____

12. Have you been convicted of a felony or a misdemeanor (besides a traffic ticket) during the past licensure period?
Yes ____ No ____. If yes, please explain on a separate sheet of paper.

13. What are the backup facilities you expect to use?
Name Address
1) Hospitals:_____

_____

2) Physicians:_____

_____ -_____

3) Other:_____

_____

I certify that the above information is true, complete, and correct.

Signature: _____ Date of Application _____

Attach affidavit of continuing education.

****

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

Date Renewal Notice Sent _____ Date Renewal Form Returned _____

Application returned on _____ for _____

Date completed application received _____ License Renewal Granted: Yes ___ No ___ Other _____

Effective Date of License _____ Application Reviewed by _____

MIDWIFE LICENSING PROGRAM
AFFIDAVIT OF CONTINUING EDUCATION
(To be attached to application for biennial renewal of license)

A.A.C. R9-16-105(C) requires a licensed midwife to obtain 10 continuing education units (CEUs) during the term of a license. A CEU is defined by the approving agency.

Units are acceptable for continuing education when approved by one of the following:
American Nurses Association
American College of Obstetrics and Gynecologists
American Medical Association
Midwives Alliance of North America
American College of Nurse Midwives

COMPLETE THE FOLLOWING:

NAME:

_____

ADDRESS

_____

CITY/STATE/ZIP

_____

TITLE SPONSOR/AGENCY DATE CITY/STATE CEUs/HOURS

_____

I hereby swear or affirm that the information given on this form is accurate and complete, and that I have maintained records as evidence of compliance.

_____

SIGNATURE DATE

Subscribed and sworn to before me this _____ day of _____, 20___.

_____

NOTARY PUBLIC

My commission expires: _____

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1).

EXHIBIT E. INDIVIDUAL QUARTERLY REPORT
ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF MATERNAL AND CHILD HEALTH
MIDWIVES QUARTERLY REPORT

_____
MIDWIFE

1. |__|__|__|__| 2. |__| |__|__|
LIC. NO. QTR. YR.

_____
REPORT PREPARED BY DATE

3. PATIENT:_____
LAST FIRST MAIDEN

4. D.O.B. |__|__| |__|__| |__|__| 5. |__|__| 6. |__|__|__|
MO. DAY YR. AGE PT. NO.

7. REGISTERED: |__|__| |__|__| |__|__|
MO. DAY YR.

8. E.D.C. |__|__| |__|__| |__|__|
MO. DAY YR.

9. DELIVERED: |__|__| |__|__| |__|__|
MO. DAY YR.

10. GRAVIDA: |__|__| 11. PARA. TERM: |__|__| PREMATURE: |__|__| ABORTIONS: |__|__| LIVING |__|__|

*12. PREV. HOME BIRTH: YES/NO

*13. REASON FOR CHOOSING H.B.:_____

ANTEPARTUM:
14. NO. MIDWIFE VISITS:_____ 15. NO. MEDICAL VISITS:_____

16. MEDICAL VISITS BY:_____ MD/DO/OTHER:_____

DATES OF FIRST AND LAST MEDICAL VISITS:_____

18. TOTAL WEIGHT GAIN: |__|__| LBS.

FORMAL ARRANGEMENT FOR MEDICAL BACK-UP:

19. PHYSICIAN:_____, MD/DO

20. HOSPITAL:_____

21. MIDWIFE CARE TERMINATED AT |__|__| WKS. GEST.

22. REASON:_____(ENTER CODE NO. FROM BACK)

LABORATORY DATA: (MOST RECENT)

STUDY	RESULT	WKS. GEST.	STUDY	RESULT	WKS. GEST.
Hemoglobin	23.	24.	Ua/Glucose	37. Pos/Neg	38.
Hematocrit	25.	26.	Ua/Protein	39. Pos/Neg	40.
Serology	27. Pos/Neg	28.	*Ua/Ketones	41. Pos/Neg	42.
*Rubella Titer	29. >1:10/<1:10	30.	*Ua/Microscopic	43. Pos/Neg	44.
Rh Factor	31. Pos/Neg	32.	G.C. Culture	45. Pos/Neg	46
*Antibody Titer	33. Pos/Neg	34.	*	47.	48.
			*	49.	50.
*Pap Smear	35. Class_____	36.	*	51.	52.

LABOR/DELIVERY: LOCATION OF: 53. LABOR_____

54. DELIVERY_____

55. FIRST STAGE |__|__| |__|__| HRS. MINS. 56. SECOND STAGE |__|__| |__|__| HRS. MINS. 57. THIRD STAGE |__|__| |__|__| HRS. MINS.

58. ROM TO DEL: |__|__| |__|__| HRS. MINS. 59. E.B.L. |__|__|__|__| ml.

NEWBORN: 60. SEX: MALE/FEMALE 61. WT. |__|__|__|__| gm. 62. LENGTH |__|__| cm.

63. H.C. |__|__| cm. 64. EST. GEST. AGE |__|__| WKS. 65. SGA / AGA / LGA

APGAR SCORE: 66. 1 MIN._____ 67. 5 MINS._____ 68. NO. CORD VESSELS |__|

69. EYE PROPHYLAXIS: NO/YES:_____ 70. DATE OF METABOLIC SCREENING |__|__| |__|__| |__|__| (AGENT) MO. DAY YR.

FOLLOWUP: 71. RhoGam: YES/NO

72. FIRST MIDWIFE VISIT AT: 24 HRS./24-48 HRS./48-72 HRS./Other:_____

73. TOTAL NO. VISITS:_____ 74. VISITS BY_____L.M./S.M./OTHER

ROUTINE PHYSICIAN EVALUATION 75. MOTHER: YES/NO 76. BABY: YES/NO

LIMITATIONS/COMPLICATIONS/CONSULTATIONS/TRANSFER: (FROM INITIAL WORK-UP THROUGH FOLLOW-UP)

77. _____NONE _____YES: (Detail on back)

CLIENT CONDITIONS/COMPLICATIONS
Check any of the following conditions/limitations/complications encountered.
Complete a CONSULTATION/TRANSPORT SUMMARY if client or newborn required transport and/or transfer to physician care, or if you have additional information/comments to provide.

INITIAL WORKUP
1. Age 15-18 Yrs. ____
2. Age >35 Yrs. ____
3. Parity > 4 ____
4. Congenital Defects ofReprod. Organs ____
5. Abn. Findings on Physical Exam ____

CONSULTATION
15. Dr. _____
16. Date _____
17. Approved for home birth: Yes No

HISTORY OF
6. Stillbirth ____
7. Neonatal Dean ____
8. Difficult Dr./Depressed Infant ____
9. Birth trauma to mother/infant ____
10. Pre-eclampsia Eclampsia ____
11. Preterm or LBW infants (2500gms/5 1/2 lbs.) ____
12. Infants 4500gm/10 lbs. or greater ____
13. Postpartum hemorrhage/transfusion ____
14. Other:_____

ANTEPARTUM
18. Elevated BP ____
19. Edema, Hands/face ____
20. Persistent headaches ____
21. Visual disturbances ____
22. Seizures ____
23. Severe Abdom. Pain ____
24. Bleeding 1st or 2nd Trimester ____
25. Bleeding 3rd Trim. ____
26. U.T.I. ____
27. HGB < 10 gm/or HCT < 30% ____
28. Varicosities, vulva/legs ____
29. Elevated Temp. ____
30. 42 Wks. Gestation ____
31. Excessive vomiting ____
32. Persistent Ketonuria ____
33. Wt. Gain < 10 lb. at Term ____
34. Shortness of Breath ____
35. Chest Pain ____
36. Other:_____

CONSULTATION

37. Dr. _____
38. Date _____
39. Approved for continued Midwife care: Yes No

FETUS

40. Abn. Growth Pattern ____
41. Expos. to Teratogens ____
42. Excessive Activity _____
43. Decreased Activity ____
44. FHT < 100 ____
45. FHT > 160 ____
46. Irreg. FHT ____
47. Cord. Prolapse ____
48. Meconium Staining ____
49. Multiple Gestation ____
50. Other:_____

CONSULTATION

51. Dr. _____
52. Date _____
53. Approved for continued Midwife care: Yes No

INTRAPARTUM

54. Bleeding 1st or 2nd Stage ____
55. Elevated BP ____
56. Elevated Temp. ____
57. Pres. not Vertex ____
58. Unengaged Head ____
59. Premature ROM ____
60. Prolonged ROM ____
61. Premature Labor ____
62. Prolonged 1st Stage ____
63. Prolonged 2nd Stage ____
64. Persistent Ketonuria ____
65. Difficult Delivery/Shoulder Dystocia ____
66. Hemorrhage in 3rd Stage or within 24 hours ____
67. Retained Placenta _____
68. Retained fragments or membranes ____
69. Uterine Atony ____
70. Laceration, 1° ____
71. Laceration, 2° ____
72. Laceration, 3° ____
73. Laceration, 4° ____
74. Laceration, periurethral ____
75. Shock ____
76. Other:_____

CONSULTATION

77. Dr. _____
78. Date _____
79. Time_____
80. Approved for continued Midwife care: Yes No

INFANT

81. APGAR < 5 @ 1 Min. ____
82. APGAR < 7 @ 5 Min. ____
83. Respiratory Distress ____
84. O2 Given ____
85. Assisted Ventilation ____
86. Cardiac Massage ____
87. Pale/Cyanotic/Gray ____
88. Meconium Stained ____
89. Foul Odor ____
90. Abn. Head Circ. ____
91. Congenital Anomaly ____
92. Preterm ____
93. Post-Term ____
94. < 2500 gm/5 1/2 lbs. ____
95. >4500 gm/10 lbs. ____
96. SGA ____
97. LGA ____
98. Flushed/Red ____
99. Abnormal Cord ____
100. Abnormal Cry ____
101. Jitteriness not resolved by feeding ____
102. Abnormal Temp. ____
103. Abn. finding on P.E. _____
104. No urination in 24 hours ____
105. No Meconium in 24 hours ____
106. Abdominal Distention ____
107. Jaundice ____
108. Poor Feeding ____
109. Other:_____

CONSULTATION

110. Dr. _____
111. Date _____
112. Time_____
113. Approved for continued Midwife care: Yes No

POSTPARTUM

114. Hemorrhage after 24 hours ____
115. Subinvolution ____
116. Uterine Infection ____
117. Unable to Void in 6 hours ____
118. Urinary Tract inf. ____
119. Breast Infection ____
120. Thrombophlebitis (positive Homan's sign ____
121. Depression ____
122. Other:_____

CONSULTATION

123. Dr. _____
124. Date _____

125. Approved for continued Midwife care: Yes No

EXHIBIT E. INDIVIDUAL QUARTERLY REPORT (continued)
ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF MATERNAL AND CHILD HEALTH
MIDWIVES QUARTERLY REPORT
CONSULTATION / TRANSPORT SUMMARY

ORIGINAL COPY TO ADHS - COPY TO MIDWIFE

_____MIDWIFE 1. /__/__/__/__/ 2. /__/ /__/__/
LIC. NO. QTR YR.

_____ 3. /__/__/__/
PATIENT NAME PT.NO.

NARRATIVE SUMMARY:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DETAILS ON TRANSFER/TRANSPORT AND OUTCOME:

4. REFERENCE NO._____

PROBLEM_____

CALL FOR TRANSPORT: 5. DATE /__/__/ /__/__/ /__/__/ 6. TIME /__/__/__/__/
MO. DAY YEAR (MILITARY TIME)

7. PARAMEDICS ____ 8. AMBULANCE ____

TRANSFER: 9. TIME /__/__/__/__/ 10. VEHICLE: RIVATE AUTO ____ AMBULANCE ____

OTHER:_____

11. DESTINATION: PHYSICIAN'S OFFICE ____ HOSPITAL ____ OTHER:_____

12. NAME OF HOSPITAL IF APPLICABLE:_____

ARRIVAL DISPOSITION: 13. DATE /__/__/ /__/__/ /__/__/ 14. /__/__/__/__/
MO. DAY YEAR (MILITARY TIME)

15. MOTHER: ____EVAL/Rx AT PHYS. OFFICE ____ADMITTED HOSPITAL

____EVAL/Rx AS OUTPATIENT AT HOSPITAL AND RELEASED

16. NEWBORN: ____EVAL/Rx AT PHYS. OFFICE ____ADMITTED TO HOSPITAL

____EVAL/Rx AS OUTPATIENT AT HOSPITAL AND RELEASED

TRANSFERRED TO NICU AT_____